		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0043398

Facility Name: BURNHAM HEALTHCARE

Address: 14500 S. MANISTEE (Number) BURNHAM (City) 60633 (Zip Code)

County: COOK

Telephone Number: (708) 862-1200 **Fax #** (708) 862-1263

IDPA ID Number: 36-4205217

Date of Initial License for Current Owners: 03/01/98

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) MORRIS ESFORMES
(Title) MANAGER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	103	Skilled (SNF)	103	37,595	1
2		Skilled Pediatric (SNF/PED)			2
3	206	Intermediate (ICF)	206	75,190	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	309	TOTALS	309	112,785	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	30,214	656	8,101	38,971	8
9	SNF/PED					9
10	ICF	71,691	808	27	72,526	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	101,905	1,464	8,128	111,497	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.86%

D. How many bed-hold days during this year were paid by Public Aid?
742 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 03/01/98

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 3/1/98 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 23 and days of care provided 7,928

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	270,425	42,575	18,158	331,158		331,158	0	331,158			1
2	Food Purchase		385,619		385,619	(6,187)	379,432	(1,631)	377,801			2
3	Housekeeping	234,039	36,284	0	270,323		270,323	0	270,323			3
4	Laundry	136,653	29,099	0	165,752		165,752	0	165,752			4
5	Heat and Other Utilities			182,704	182,704		182,704	612	183,316			5
6	Maintenance	153,993	35,990	78,167	268,150		268,150	4,628	272,778			6
7	Other (specify):*			29,227	29,227		29,227	237	29,464			7
8	**TOTAL General Services**	795,110	529,567	308,256	1,632,933	(6,187)	1,626,746	3,846	1,630,592			8
	B. Health Care and Programs											
9	Medical Director	0		5,000	5,000		5,000	0	5,000			9
10	Nursing and Medical Records	3,145,549	164,459	47,167	3,357,175		3,357,175	0	3,357,175			10
10a	Therapy	0		5,523	5,523		5,523	0	5,523			10a
11	Activities	113,183	31,387	3,648	148,218		148,218	0	148,218			11
12	Social Services	223,652		5,230	228,882		228,882	0	228,882			12
13	Nurse Aide Training			0	0		0	0	0			13
14	Program Transportation			0	0		0	0	0			14
15	Other (specify):*				0		0	0	0			15
16	**TOTAL Health Care and Programs**	3,482,384	195,846	66,568	3,744,798	0	3,744,798	0	3,744,798			16
	C. General Administration											
17	Administrative	136,264		891,000	1,027,264		1,027,264	(837,543)	189,721			17
18	Directors Fees			0	0		0	0	0			18
19	Professional Services			90,589	90,589		90,589	20,583	111,172			19
20	Dues, Fees, Subscriptions & Promotions			32,509	32,509		32,509	(14,066)	18,443			20
21	Clerical & General Office Expenses	203,056	31,321	131,894	366,271		366,271	20,780	387,051			21
22	Employee Benefits & Payroll Taxes			708,224	708,224	6,187	714,411	0	714,411			22
23	Inservice Training & Education			2,602	2,602		2,602	199	2,801			23
24	Travel and Seminar			0	0		0	0	0			24
25	Other Admin. Staff Transportation			34,918	34,918		34,918	1,388	36,306			25
26	Insurance-Prop.Liab.Malpractice			181,566	181,566		181,566	7,110	188,676			26
27	Other (specify):*			457,812	457,812		457,812	(438,632)	19,180			27
28	**TOTAL General Administration**	339,320	31,321	2,531,114	2,901,755	6,187	2,907,942	(1,240,181)	1,667,761			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,616,814	756,734	2,905,938	8,279,486	0	8,279,486	(1,236,335)	7,043,151			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number BURNHAM HEALTHCARE #0043398 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			552,180	552,180		552,180	(60,806)	491,374			30
31	Amortization of Pre-Op. & Org.			47,441	47,441		47,441	0	47,441			31
32	Interest			1,338,422	1,338,422		1,338,422	3,152	1,341,574			32
33	Real Estate Taxes			595,738	595,738		595,738	1,385	597,123			33
34	Rent-Facility & Grounds			17,798	17,798		17,798	(17,798)	0			34
35	Rent-Equipment & Vehicles			44,126	44,126		44,126	8,868	52,994			35
36	Other (specify):*				0		0	0	0			36
37	**TOTAL Ownership**			2,595,705	2,595,705	0	2,595,705	(65,199)	2,530,506			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		136,205	370,647	506,852		506,852	0	506,852			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			169,177	169,177		169,177	0	169,177			42
43	Other (specify):*				0		0	0	0			43
44	**TOTAL Special Cost Centers**	0	136,205	539,824	676,029	0	676,029	0	676,029			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,616,814	892,939	6,041,467	11,551,220	0	11,551,220	(1,301,534)	10,249,686			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(63,823)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,631)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	(11,143)	21		18
19	Entertainment	0	20		19
20	Contributions	(4,122)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(457,812)	27		24
25	Fund Raising, Advertising and Promotional	(11,510)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	0	20		28
29	Other-Attach Schedule SEE PAGE 5A	(213,129)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (763,170)		$ 0	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(538,364)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (538,364)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,301,534)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

BURNHAM HEALTHCARE

ID# 0043398

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ -1629	6	1
2	NON ALLOWABLE MANAGEMENT FEES	(211,500)	17	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(213,129)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,631)	0	0	0	0	0	0	0	0	0	0	(1,631)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	612	0	0	0	0	0	0	0	612	5
6	Maintenance	(1,629)	0	4,547	1,710	0	0	0	0	0	0	0	4,628	6
7	Other (specify):*	0	0	237	0	0	0	0	0	0	0	0	237	7
8	**TOTAL General Services**	(3,260)	0	4,784	2,322	0	0	0	0	0	0	0	3,846	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(211,500)	(626,043)	0	0	0	0	0	0	0	0	0	(837,543)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	986	19,453	144	0	0	0	0	0	0	0	20,583	19
20	Fees, Subscriptions & Promotions	(15,632)	0	1,566	0	0	0	0	0	0	0	0	(14,066)	20
21	Clerical & General Office Expenses	(11,143)	15,264	16,050	609	0	0	0	0	0	0	0	20,780	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	199	0	0	0	0	0	0	0	0	199	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	1,042	346	0	0	0	0	0	0	0	0	1,388	25
26	Insurance-Prop.Liab.Malpractice	0	1,784	5,169	157	0	0	0	0	0	0	0	7,110	26
27	Other (specify):*	(457,812)	6,402	12,778	0	0	0	0	0	0	0	0	(438,632)	27
28	**TOTAL General Administration**	(696,087)	(600,565)	55,561	910	0	0	0	0	0	0	0	(1,240,181)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(699,347)	(600,565)	60,345	3,232	0	0	0	0	0	0	0	(1,236,335)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(63,823)	685	874	1,458	0	0	0	0	0	0	0	(60,806)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	956	2,196	0	0	0	0	0	0	0	3,152	32
33	Real Estate Taxes	0	0	0	1,385	0	0	0	0	0	0	0	1,385	33
34	Rent-Facility & Grounds	0	0	0	(17,798)	0	0	0	0	0	0	0	(17,798)	34
35	Rent-Equipment & Vehicles	0	2,997	5,871	0	0	0	0	0	0	0	0	8,868	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(63,823)	3,682	7,701	(12,759)	0	0	0	0	0	0	0	(65,199)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(763,170)	(596,883)	68,046	(9,527)	0	0	0	0	0	0	0	(1,301,534)	45

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
MORRIS ESFORMES	38	LIST ATTACHED		EKS MNGMNT	LINCOLNWOOD	MANAGEMENT
PHILIP ESFORMES	19			EMI ENTERPRISE	LINCOLNWOOD	CONSULTING
MICHAEL ROSEN	5			IME REALTY CORP	LINCOLNWOOD	HOME OFFICE
NACHSON DRAIMAN	38					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$ 659,500	EMI ENTERPRISE		$	$ (659,500)	1
2	V								2
3	V	17	OFFICERS SALARY		" "		33,457	33,457	3
4	V	19	ACCOUNTING FEES		" "		986	986	4
5	V	21	OFFICE EXPENSE		" "		15,264	15,264	5
6	V	25	TRANSPORTATION		" "		1,042	1,042	6
7	V	26	INSURANCE		" "		1,784	1,784	7
8	V	27	EMPLOYEE BENEFITS		" "		6,402	6,402	8
9	V	30	DEPRECIATION		" "		685	685	9
10	V	35	AUTO LEASE		" "		2,997	2,997	10
11	V								11
12	V								12
13	V								13
14	Total			$ 659,500			$ 62,617	$ * (596,883)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	BOOKKEEPING FEES	$ 60,000	EKS MANAGEMENT		$	$ (60,000)	15
16	V								16
17	V	6	PAINTING / DECORATING		" "		4,547	4,547	17
18	V	7	SCAVENGER		" "		237	237	18
19	V	19	PROFESSIONAL FEES		" "		19,453	19,453	19
20	V	20	WANT ADS		" "		1,566	1,566	20
21	V	21	OFFICE EXPENSE		" "		76,050	76,050	21
22	V	23	SEMINARS		" "		199	199	22
23	V	25	TRANSPORTATION		" "		346	346	23
24	V	26	INSURANCE		" "		5,169	5,169	24
25	V	27	EMPLOYEE BENEFITS		" "		12,778	12,778	25
26	V	30	DEPRECIATION		" "		874	874	26
27	V	32	INTEREST - INS. FINANCING		" "		956	956	27
28	V	35	EQUIPMENT RENT		" "		5,871	5,871	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 60,000			$ 128,046	$ * 68,046	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	OFFICE RENT	$ 17,798	IME REALTY CORP		$	$ (17,798)	15
16	V								16
17	V	5	UTILITIES		" "		612	612	17
18	V	6	REPAIRS & MAINTENANCE		" "		1,710	1,710	18
19	V	19	PROFESSIONAL FEES		" "		144	144	19
20	V	21	OFFICE EXPENSE		" "		609	609	20
21	V	26	INSURANCE		" "		157	157	21
22	V	30	DEPRECIATION		" "		1,458	1,458	22
23	V	32	INTEREST		" "		2,196	2,196	23
24	V	33	RE TAX		" "		1,385	1,385	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 17,798			$ 8,271	$ * (9,527)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MORRIS ESFORMES	OFFICER	MANAGEMENT	38.00	151,543			MNMNT FEES	$ 33,457	17-7	1
2	PHILIP ESFORMES		MANAGEMENT	19.00				MNMNT FEES	20,000	17-3	2
3	NACHSON DRAIMAN			38.00							3
4	MICHAEL ROSEN			5.00							4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 53,457		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: EMI ENTERPRISES
Street Address: 3737 W. ARTHUR
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674-1946
Fax Number: (847) 674-1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	OFFICERS SALARY	PATIENT DAYS	616,513	11	$ 185,000	$ 185,000	111,497	$ 33,457	1
2	19	ACCOUNTING FEES	PATIENT DAYS	616,513	11	5,451		111,497	986	2
3	21	OFFICE EXPENSE	PATIENT DAYS	616,513	11	84,399	60,672	111,497	15,264	3
4	25	TRANSPORTATION	PATIENT DAYS	616,513	11	5,763		111,497	1,042	4
5	26	INSURANCE	PATIENT DAYS	616,513	11	9,863		111,497	1,784	5
6	27	EMPLOYEE BENEFITS	PATIENT DAYS	616,513	11	35,399		111,497	6,402	6
7	30	DEPRECIATION	PATIENT DAYS	616,513	11	3,788		111,497	685	7
8	35	AUTO LEASE	PATIENT DAYS	616,513	11	16,569		111,497	2,997	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 346,232	$ 245,672		$ 62,617	25

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: EKS MANAGEMENT
Street Address: 3737 W. ARTHUR
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674-1946
Fax Number: (847) 674-1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	PAINTING & DECORATING	PATIENT DAYS	616,513	11	$ 25,141	$	111,497	$ 4,547	1
2	7	SCAVENGER	PATIENT DAYS	616,513	11	1,310		111,497	237	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	616,513	11	107,563	91,129	111,497	19,453	3
4	20	WANT ADS	PATIENT DAYS	616,513	11	8,660		111,497	1,566	4
5	21	TOTAL OFFICE	PATIENT DAYS	616,513	11	420,511	316,407	111,497	76,050	5
6	23	SEMINARS	PATIENT DAYS	616,513	11	1,100		111,497	199	6
7	25	TRANSPORTATION	PATIENT DAYS	616,513	11	1,912		111,497	346	7
8	26	INSURANCE	PATIENT DAYS	616,513	11	28,579		111,497	5,169	8
9	27	EMPLOYEE BENEFITS	PATIENT DAYS	616,513	11	70,657		111,497	12,778	9
10	30	DEPRECIATION	PATIENT DAYS	616,513	11	4,837		111,497	874	10
11	32	INTEREST - INS. FINANCE	PATIENT DAYS	616,513	11	5,286		111,497	956	11
12	35	EQUIPMENT RENT	PATIENT DAYS	616,513	11	32,463		111,497	5,871	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 708,019	$ 407,536		$ 128,046	25

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: IME REALTY CORP
Street Address: 3737 W. ARTHUR
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674-1946
Fax Number: (847) 674-1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	INCOME	100	11	$ 6,990	$	9	$ 612	1
2	6	REPAIRS & MAINTENANCE	INCOME	100	11	19,525		9	1,710	2
3	19	PROFESSIONAL FEES	INCOME	100	11	1,650		9	144	3
4	21	OFFICE EXPENSE	INCOME	100	11	6,958		9	609	4
5	26	INSURANCE	INCOME	100	11	1,798		9	157	5
6	30	DEPRECIATION	INCOME	100	11	16,647		9	1,458	6
7	32	INTEREST	INCOME	100	11	25,074		9	2,196	7
8	33	RE TAX	INCOME	100	11	15,815		9	1,385	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 94,457	$		$ 8,271	25

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	COLE TAYLOR		X	MORTGAGE	$129,077.00	05/24/00	$ 15,700,000	$ 15,460,550	06/01/05	0.0875	$ 1,338,422	1
2												2
3												3
4												4
5												5
	Working Capital											
6	RELATED PARTY										3,152	6
7												7
8												8
9	TOTAL Facility Related				$129,077.00		$ 15,700,000	$ 15,460,550			$ 1,341,574	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 0	$ 0			$ 0	14
15	TOTALS (line 9+line14)						$ 15,700,000	$ 15,460,550			$ 1,341,574	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 577,666	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 586,702	2
3. Under or (over) accrual (line 2 minus line 1).		$ 9,036	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 586,702	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 595,738	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	0	8
	1997	505,388	9
	1998	516,010	10
	1999	577,666	11
	2000	586,702	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2000 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BURNHAM HEALTHCARE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0043398

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200(

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	30-06-313-040-000 VOL 220		$ 477,978.00	$ 477,978.00
2.	30-06-313-054-000 VOL 220		$ 70,770.00	$ 70,770.00
3.	30-06-313-053-000 VOL 220		$ 4,996.00	$ 4,996.00
4.	30-06-313-052-000 VOL 220		$ 7,591.00	$ 7,591.00
5.	30-06-313-051-000 VOL 220		$ 23,293.00	$ 23,293.00
6.	30-06-313-045-000 VOL 220		$ 2,074.00	$ 2,074.00
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 586,702.00	$ 586,702.00

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services' _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill whic is normally paid during 2001.

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 72,554 B. General Construction Type: Exterior 3 STORY Frame BRICK Number of Stories 3

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 0
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 0
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1			1998	$ 1,500,000	1
2					2
3	TOTALS			$ 1,500,000	3

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	309		1998		$ 12,649,700	$ 324,351	39	$ 324,351	$	$ 1,229,831	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	ROOF			1998	74,000	1,898	39	1,898		6,722	9
10	WALLCOVERINGS			1998	39,379	1,009	39	1,009		3,574	10
11	PAINTING			1998	12,962	333	39	333		1,179	11
12	WINDOW TREATMENTS			1998	38,112	977	39	977		3,460	12
13	FENCE			1998	650	17	39	17		60	13
14	NEW WINDOWS			1998	20,445	524	39	524		1,856	14
15	PAINTER'S SALARIES			1998	64,064	1,643	39	1,643		5,819	15
16	NURSE STATION			1998	23,100	592	39	592		2,097	16
17	TILING			1998	635	16	39	16		57	17
18	BUILT IN CABINETRY			1998	64,700	1,659	39	1,659		5,753	18
19	NEW COILS FOR AHV			1998	6,000	154	39	154		391	19
20	NEW BOILER			1998	20,328	521	39	521		1,324	20
21	HOT WATER TANK			1998	2,750	71	39	71		180	21
22	ROOF			1999	29,500	756	39	756		1,922	22
23	PATIO			1999	5,080	339	15	339		861	23
24	AWNING			1999	3,000	200	15	200		508	24
25	LIGHTS			1999	7,603	195	39	195		496	25
26	NURSE CALL STATION			1999	1,957	50	39	50		127	26
27	WINDOW TREATMWNTS			1999	11,207	287	39	287		730	27
28	CORRIDOR BORDERS			1999	6,154	158	39	158		401	28
29	SCREENS			2000	3,543	129	27.5	129		199	29
30	AIR CONDITIONER REPLACEMENT			2001	14,540	286	27.5	286		286	30
31	DOOR DETECTOR			2001	1,800	35	27.5	35		35	31
32	A/C COMPRESSOR & REBUILT AIR HANDLER			2001	22,621	446	27.5	446		446	32
33	ROOF VENTILATORS			2001	6,898	136	27.5	136		136	33
34	BOILER			2001	63,746	1,256	27.5	1,256		1,256	34
35	WALK IN FREEZER			2001	3,750	74	27.5	74		74	35
36	DOOR			2001	2,970	58	27.5	58		58	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	DRYER EXHAUST FAN	2001	$ 4,050	$ 80	27.5	$ 80	$	$ 80	37
38	DOORS	2001	1,995	39	27.5	39		39	38
39	DOORS	2001	1,723	34	27.5	34		34	39
40	FLOOR TILING & CARPETING	2001	4,497	899	5	899		899	40
41	DRAPERIES	2001	12,722	2,544	5	2,544		2,544	41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 13,226,181	$ 341,766		$ 341,766	$ 0	$ 1,273,434	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,433,927	$ 197,620	$ 143,393	$ (54,227)		$ 476,022	71
72	Current Year Purchases	63,968	12,794	3,198	(9,596)		3,198	72
73	Fully Depreciated Assets				0			73
74	RELATED PARTY		3,017	3,017	0			74
75	TOTALS	$ 1,497,895	$ 213,431	$ 149,608	$ (63,823)		$ 479,220	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$ 0		$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			$ 0	$ 0	$ 0	$ 0		$ 0	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 16,224,076	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 555,197	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 491,374	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (63,823)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,752,654	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: $ 22,262 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	ADMINISTRATIVE	2001 HONDA ODYSSEY	$ 496.00	$ 5,950	17
18	NURSING	2000 JEEP CHEROKEE	417.00	5,052	18
19	FACILITY	2000 FORD EXPLORER	699.00	3,546	19
20	FACILITY	2001 CHEVY VAN TRUCK	836.00	7,316	20
21	TOTAL		$ 2,448.00	$ 21,864	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	Nurse Aide Competency Tests				0
9	TOTALS	$ 0	$ 0	$ 0	$ 0
10	SUM OF line 9, col. 1 and 2 (e)	$ 0			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$ 182,165	$		$ 182,165	1
2	Licensed Speech and Language Development Therapist		hrs			43,657			43,657	2
3	Licensed Recreational Therapist		hrs			126,651			126,651	3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				110,881		110,881	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): LAB					18,174	25,324		43,498	13
14	TOTAL			$		$ 370,647	$ 136,205		$ 506,852	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2001 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 265,866	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,860,674		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	296,806		6
7	Other Prepaid Expenses	1,118		7
8	Accounts Receivable (owners or related parties)	273,199		8
9	Other(specify):	208,503		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,906,166	$ 0	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,500,000		13
14	Buildings, at Historical Cost	12,649,700		14
15	Leasehold Improvements, at Historical Cost	576,481		15
16	Equipment, at Historical Cost	1,497,895		16
17	Accumulated Depreciation (book methods)	(2,226,700)		17
18	Deferred Charges	237,205		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(75,115)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 14,159,466	$ 0	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 18,065,632	$ 0	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 354,014	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	247,836		30
31	Accrued Taxes Payable (excluding real estate taxes)	26,654		31
32	Accrued Real Estate Taxes(Sch.IX-B)	586,702		32
33	Accrued Interest Payable	100,022		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Lessor/Prior Owner	245,489		36
37	Due to Related Parties	175,838		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,736,555	$ 0	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	15,460,550		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 15,460,550	$ 0	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 17,197,105	$ 0	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 868,527	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 18,065,632	$ 0	48

***(See instructions.)**

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 874,160	1
2	Restatements (describe):		2
3	STATE REPLACEMENT TAX	(22,285)	3
4	POST CLOSING ENTRIES	(14,762)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 837,113	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,016,414	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(985,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 31,414	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 0	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 868,527	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 12,361,285	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 12,361,285	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	184,214	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 184,214	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 0	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	22,135	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 22,135	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 0	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,567,634	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,632,933	31
32	Health Care	3,744,798	32
33	General Administration	2,901,755	33
	B. Capital Expense		
34	Ownership	2,595,705	34
	C. Ancillary Expense		
35	Special Cost Centers	506,852	35
36	Provider Participation Fee	169,177	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,551,220	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,016,414	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,016,414	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	3,882	4,313	$ 132,626	$ 30.75	1
2	Assistant Director of Nursing					2
3	Registered Nurses	29,200	30,556	692,367	22.66	3
4	Licensed Practical Nurses	40,340	42,463	723,140	17.03	4
5	Nurse Aides & Orderlies	152,633	162,376	1,333,111	8.21	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	16,362	16,868	113,183	6.71	10
11	Social Service Workers	19,881	22,429	223,652	9.97	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	35,652	37,928	270,425	7.13	15
16	Dishwashers					16
17	Maintenance Workers	16,483	17,089	153,993	9.01	17
18	Housekeepers	31,318	33,675	234,039	6.95	18
19	Laundry	20,487	21,795	136,653	6.27	19
20	Administrator	3,628	3,779	136,264	36.06	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,292	2,635	33,333	12.65	23
24	Clerical	14,120	14,755	169,723	11.50	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	10,075	10,495	76,926	7.33	31
32	Other Health Care(specify)	11,177	11,786	187,379	15.90	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	407,530	432,942	$ 4,616,814 *	$ 10.66	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 18,158	1-3	35
36	Medical Director	M	5,000	9-3	36
37	Medical Records Consultant	O	4,626	10-3	37
38	Nurse Consultant	N	23,469	10-3	38
39	Pharmacist Consultant	T	7,222	10-3	39
40	Physical Therapy Consultant	H	0	10a-3	40
41	Occupational Therapy Consultant	L	153	10a-3	41
42	Respiratory Therapy Consultant	Y	5,000	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	F	3,648	11-3	44
45	Social Service Consultant	E	5,230	12-3	45
46	Other(specify) Dental	E	3,600	10-3	46
47	Physicians	S	6,000	10-3	47
48	Psychiatric		2,250	10-3	48
49	TOTAL (lines 35 - 48)		$ 84,356		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
YOSEF MEYSTEL	ADMIN		$ 136,264
	ASST ADMIN		0
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 136,264

B. Administrative - Other

Description		Amount
EMI	- MANAGEMENT FEES	$ 659,500
PHILIP ESFORMES	- MANAGEMENT FEES	231,500
TOTAL (agree to Schedule V, line 17, col. 3)		$ 891,000
(Attach a copy of any management service agreement)		

C. Professional Services

Vendor/Payee	Type	Amount
ALPHA DATA	DATA PROCESSING	$ 7,522
CDW	DATA PROCESSING	147
INFORMATION DATA	DATA PROCESSING	1,581
HDSI	DATA PROCESSING	18,600
MAXXSOURCE	DATA PROCESSING	1,375
MID AMERICA	DATA PROCESSING	2,640
KRUPNICK BOKOR	ACCOUNTING	11,100
GENSON & GILLESPIE	LEGAL	1,609
MCBRIDE BAKER & COLE	LEGAL	18,095
NASH, LALICH & KRALOVEC	LEGAL	20,990
RICHARD PEELO	MEDICARE CONSULT.	4,500
PERSONNEL PLANNERS	UNEMPLOYMENT CON.	2,430
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 90,589

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 113,383
Unemployment Compensation Insurance	27,560
FICA Taxes	351,724
Employee Health Insurance	165,689
Employee Meals	6,187
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	49,868
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	0
	0
	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 714,411

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	7,426
Health Care Worker Background Check	0
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	11,510
RELATED PARTY-EKS WANT ADS	1,566
CONTRIBUTIONS	4,122
DUES & SUBSCRIPTIONS	5,535
LICENSES & PERMITS	3,916
Less: Public Relations Expense	(4,122)
Non-allowable advertising	(11,510)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,443

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	PAINT/DECORATING	1998	$ 3,683	3 YRS	$ 614	$ 1,228	$ 1,228	$ 613	$	$	$	$	$
2	PAINT/DECORATING	1999	1,866	3 YRS		311	622	622	311				
3	PAINT/DECORATING	2001	3,437	3 YRS				573	1,146	1,146	572		
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 8,986		$ 614	$ 1,539	$ 1,850	$ 1,808	$ 1,457	$ 1,146	$ 572	$	$

Facility Name & ID Number BURNHAM HEALTHCARE # 0043398 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? YES

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL COUNCIL LONG TERM CARE $5535

(3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 2,401 Line 10-2

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 169,177
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 6,187 Has any meal income been offset against related costs? N/A Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: BURNHAM HEALTHCARE **#0043398** **Report Period Beginning: 01/01/2001** **Ending: 12/31/2001**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	18,158	
	REPAIRS & MAINTENANCE		0	
			0	18,158
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
			0	0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		64,197	
	ELECTRICITY		71,447	
	WATER		47,060	
	CABLE TV - LOBBY		0	
			0	182,704
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		2,745	
	PAINTING & DECORATING		3,437	
	BUILDING REPAIRS		12,646	
	MAINTENANCE TRAVEL		40,218	
	EQUIPMENT MAINTENANCE & REPAIR		0	
	ELEVATOR MAINTENANCE & REPAIR		10,803	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		4,619	
	FIRE SERVICE		3,699	
			0	
			0	
			0	78,167
7	**OTHER**			
	SCAVENGER		18,655	
	SECURITY SERVICE		10,572	29,227
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	5,000	5,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	4,626	
	PHARMACY CONSULTANT	XVIII B 39-2	7,222	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	6,000	
	PSYCHIATRIC	XVIII B __-2	2,250	
	RN CONSULTANT	XVIII B 38-2	23,469	
	DENTAL		3,600	
			0	47,167
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		370	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	153	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	5,000	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	5,523
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	3,648	
			0	3,648
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	663	
	SOCIAL WORKER	XVIII B 45-2	4,567	
			0	5,230
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number BURNHAM HEALTHCARE **#0043398** **Report Period Beginning: 01/01/2001** **Ending: 12/31/2001**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	891,000	891,000
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	31,865	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	58,724	
			0	90,589
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	11,510	
	EMPLOYEE WANT ADS	XIX F	7,426	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	5,535	
	LICENSES & PERMITS	XIX F	3,916	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	4,122	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	0	32,509
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES		590	
	EQUIPMENT REPAIR & MAINTENANCE		5,221	
	OUTSIDE CLERICAL SERVICES		84,000	
	PENALTIES / OVERDRAFT CHARGES	VI 18	11,143	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		30,940	
	MESSENGER SERVICE		0	
			0	131,894

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	351,724	
	UNEMPLOYMENT COMPENSATION	XIX D	27,560	
	WORKERS COMPENSATION INSURANC	XIX D	113,383	
	HOSPITALIZATION INSURANCE	XIX D	165,689	
	EMPLOYEE BENEFITS - OTHER	XIX D	49,868	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	708,224
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		2,602	2,602
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
			0	
			0	0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		34,918	34,918
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		181,566	181,566
27	**OTHER**			
	BAD DEBTS	VI 24	457,812	
			0	457,812

GRAND TOTAL COLUMN 3 OTHER 2,905,938

BURNHAM HEALTHCARE
EMPLOYEE MEAL RECLASSIFICATION
12/31/2001

TOTAL FOOD PURCHASE	385,619
LESS SALES TAX	(1,631)
NET FOOD	383,988
TOTAL PATIENT CENSUS	111,497
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	334491
ADD # EMPLOYEE MEALS/DAY	15
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	5475

PATIENT MEALS	334491
ADD EMPLOYEE MEALS	5475
TOTAL MEALS/YEAR	339966
NET FOOD	383988
DIVIDE TOTAL MEALS/YEAR	339966
COST PER MEAL	1.13
TIME EMPLOYEE MEALS	5475
EMPLOYEE MEAL RECLASSIFICATION	6187